Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Maryland HCS (VAMC Baltimore - 512, VAMC Fort Howard - 512A4 and VAMC Perry Point - 512A5)

VISN 5

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 3050

2. Point-in-time estimate of Veterans who are Chronically Homeless: 963

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **3050** (point-in-time estimate of homeless veterans in service area) **X 34%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 92%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 963** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1300	175
Transitional Housing Beds	250	150
Permanent Housing Beds	0	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Partnering with Baltimore Homeless Services. Explore possibility of establishing VASH program.
Glasses	Informal partnering with local Lion's Club. Outreach to eyeglass retailers to establish mechanisms for serving the homeless.
Other	Need: Shelter for family care. Partner with local department of social services to establish resources and develop resource guide for families.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 12 Non-VA staff Participants: 92%
Homeless/Formerly Homeless: 8%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.64	42%	2.25	1
2	Glasses	1.67	33%	2.67	6
3	Dental care	2	25%	2.34	2
4	Eye care	2	0%	2.65	5
5	Child care	2.08	0%	2.39	3
6	Help managing money	2.17	8%	2.71	7
7	SSI/SSD process	2.33	0%	3.02	19
8	Legal assistance	2.33	8%	2.61	4
9	Job training	2.5	0%	2.88	14
10	Halfway house or transitional living facility	2.58	17%	2.76	8
11	Guardianship (financial)	2.58	8%	2.76	9
12	Help with finding a job or getting employment	2.75	8%	3.00	17
13	Help with transportation	2.75	0%	2.82	11
14	Education	2.92	0%	2.88	13
15	Emergency (immediate) shelter	3	17%	3.04	20
16	Drop-in center or day program	3	0%	2.77	10
17	Welfare payments	3	0%	2.97	16
18	Discharge upgrade	3.08	0%	2.90	15
19	Detoxification from substances	3.17	0%	3.11	22
20	Treatment for dual diagnosis	3.17	0%	3.01	18
21	Family counseling	3.17	0%	2.85	12
22	Help getting needed documents or identification	3.17	0%	3.16	23
23	Women's health care	3.25	0%	3.09	21
24	Help with medication	3.33	0%	3.18	24
25	Treatment for substance abuse	3.42	8%	3.30	28
26	Services for emotional or psychiatric problems	3.42	8%	3.20	25
27	VA disability/pension	3.5	0%	3.33	29
28	TB treatment	3.64	0%	3.45	33
29	Spiritual	3.67	0%	3.30	27
30	Food	3.75	0%	3.56	35
31	Clothing	3.75	0%	3.40	31
32	Medical services	3.75	0%	3.55	34
33	AIDS/HIV testing/counseling	3.75	0%	3.38	30
34	TB testing	3.83	0%	3.58	36
35	Hepatitis C testing	3.83	0%	3.41	32
36	Personal hygiene (shower, haircut, etc.)	3.92	8%	3.21	26

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.08	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.42	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.83	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.17	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.5	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.33	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.67	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.75	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.91	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.64	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.09	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.45	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.1	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.6	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.7	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.8	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.6	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.4	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.9	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Martinsburg, WV - 613

VISN 5

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 164

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **164** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	16	25
Transitional Housing Beds	111	24
Permanent Housing Beds	39	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Help with Transportation	This is such a big need in our rural area. The situation is somewhat improved this year by getting more regular program money for bus passes, and cooperation from Pan Tran in adding additional bus routes and stops. We anticipate more transportation assistance from: one of our partners (Destiny Church) through a grant; obtaining a daily volunteer driver for our program; and attempting to pool funding and resources with our own Mental Health Service Line Veterans Industries Program.
Transitional living facility	1. Assist in setting up/monitoring and referring of veterans to new VA Grant and Per Diem facility in Martinsburg. 2. Assist VA Mental Health Service Line in securing transitional residence for CWT workers in Martinsburg. 3. Continue to increase contacts through our outreach worker, with transitional housing sites in Baltimore and DC areas. We are working with three partners (two local housing authorities, Telamon Corporation) to develop permanent housing.
Job Training	Plan to hold at least two job fairs with employment services and employers present. Will inventory existing job training resources for possible future use.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 27 Non-VA staff Participants: 85%
Homeless/Formerly Homeless: 7%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.04	5%	2.34	2
2	Child care	2.04	5%	2.39	3
3	Drop-in center or day program	2.13	5%	2.77	10
4	Family counseling	2.17	5%	2.85	12
5	Guardianship (financial)	2.25	5%	2.76	9
6	Help managing money	2.29	0%	2.71	7
7	Long-term, permanent housing	2.46	26%	2.25	1
8	Help with transportation	2.46	57%	2.82	11
9	Education	2.54	5%	2.88	13
10	Eye care	2.58	0%	2.65	5
11	Legal assistance	2.67	5%	2.61	4
12	Glasses	2.75	0%	2.67	6
13	Job training	2.83	19%	2.88	14
14	Halfway house or transitional living facility	2.96	10%	2.76	8
15	Welfare payments	3	0%	2.97	16
16	Discharge upgrade	3.22	0%	2.90	15
17	Treatment for dual diagnosis	3.25	5%	3.01	18
18	SSI/SSD process	3.36	5%	3.02	19
19	Emergency (immediate) shelter	3.38	5%	3.04	20
20	Personal hygiene (shower, haircut, etc.)	3.42	5%	3.21	26
21	Services for emotional or psychiatric problems	3.42	10%	3.20	25
22	Women's health care	3.54	0%	3.09	21
23	Help with medication	3.58	0%	3.18	24
24	Help with finding a job or getting employment	3.63	14%	3.00	17
25	Help getting needed documents or identification	3.63	5%	3.16	23
26	Clothing	3.67	0%	3.40	31
27	Food	3.71	5%	3.56	35
28	VA disability/pension	3.71	5%	3.33	29
29	Treatment for substance abuse	3.75	10%	3.30	28
30	TB treatment	3.75	0%	3.45	33
31	Detoxification from substances	3.92	0%	3.11	22
32	AIDS/HIV testing/counseling	3.92	0%	3.38	30
33	TB testing	3.92	0%	3.58	36
34	Medical services	4.08	0%	3.55	34
35	Hepatitis C testing	4.08	0%	3.41	32
36	Spiritual	4.08	0%	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.15	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.44	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.22	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.48	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.35	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.12	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.92	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.81	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.36	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.83	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.24	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.64	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.16	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.36	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.79	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.36	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.08	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.25	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.6	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Washington, DC - 688

VISN 5

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 2700

2. Point-in-time estimate of Veterans who are Chronically Homeless: 512

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **2700** (point-in-time estimate of homeless veterans in service area) **X 20%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 94%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 512** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	175	20
Transitional Housing Beds	343	20
Permanent Housing Beds	3	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Increase referrals to Pathways and Mental Health Care Service Agencies and HUD Shelter Plus Care.
Child Care	Investigate available child care resources and add resource list to homeless service provider packet.
Help Managing Money	Sponsor an educational forum by end of March 2005 to include fiduciary unit, a representative payee, veterans service organizations, a community agency prepared to offer technical assistance to establish a guardianship unit, and veterans who have guardians.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 31 Non-VA staff Participants: 68%
Homeless/Formerly Homeless: 3%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.54	48%	2.25	1
2	Child care	1.85	0%	2.39	3
3	Halfway house or transitional living facility	1.89	33%	2.76	8
4	Dental care	2	7%	2.34	2
5	Help managing money	2.15	4%	2.71	7
6	Discharge upgrade	2.19	4%	2.90	15
7	Eye care	2.22	4%	2.65	5
8	Guardianship (financial)	2.22	4%	2.76	9
9	Glasses	2.26	4%	2.67	6
10	Help with finding a job or getting employment	2.26	11%	3.00	17
11	Legal assistance	2.26	4%	2.61	4
12	Help with transportation	2.37	0%	2.82	11
13	Family counseling	2.41	4%	2.85	12
14	Education	2.46	0%	2.88	13
15	SSI/SSD process	2.54	4%	3.02	19
16	Welfare payments	2.56	0%	2.97	16
17	Help getting needed documents or identification	2.58	0%	3.16	23
18	Job training	2.61	11%	2.88	14
19	Detoxification from substances	2.69	7%	3.11	22
20	Spiritual	2.69	4%	3.30	27
21	Treatment for dual diagnosis	2.72	0%	3.01	18
22	Women's health care	2.72	0%	3.09	21
23	Services for emotional or psychiatric problems	2.76	11%	3.20	25
24	Help with medication	2.82	0%	3.18	24
25	Emergency (immediate) shelter	2.87	11%	3.04	20
26	Drop-in center or day program	2.87	0%	2.77	10
27	VA disability/pension	2.89	7%	3.33	29
28	Hepatitis C testing	3	4%	3.41	32
29	Treatment for substance abuse	3.03	4%	3.30	28
30	Personal hygiene (shower, haircut, etc.)	3.07	0%	3.21	26
31	Clothing	3.07	4%	3.40	31
32	TB treatment	3.11	0%	3.45	33
33	Medical services	3.14	0%	3.55	34
34	Food	3.21	0%	3.56	35
35	AIDS/HIV testing/counseling	3.21	0%	3.38	30
36	TB testing	3.25	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.25	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.56	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.24	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.52	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.16	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.72	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.11	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.76	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.06	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.5	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.35	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.41	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.17	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.44	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.59	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.65	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.53	1.84